TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TX HEALTH DBA INJURY 1-DALLAS

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-17-2119-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
MARCH 14, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Travelers has established an unfair and unreasonable time frame for paying for the services that were medically necessary."

Requestor's Supplemental Position Summary: "Yes, we received the payment but the amount of hours that were paid was incorrect. The total number of hours the patient completed was 8 and the reimbursement was only for 1. The claim was corrected on 12/20/16 stating the number of units is 8 per the documentation."

Requestor's Supplemental Position Summary: "Yes, payment was received but DOS 10/03/16 was paid incorrectly."

Amount in Dispute: $6,125.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement is being issued in accordance with the Texas Workers' Compensation Act and adopted Rules of the Division of Workers' Compensation."

Position Summary Submitted by: William Weldon/Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 3, 2016 through November 4, 2016	Chronic Pain Management Program CPT Code 97799-CP-CA (49 hours)	$6,125.00	$887.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197-Payment denied/reduced for absence of precertification/authorization.

- P12-Workers compensation jurisdictional fee schedule adjustment.
- 1001-Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- W3-Additional payment made on appeal/reconsideration.

Issues

1. What are the services in dispute?
2. Does a preauthorization issue exist?
3. Is the requestor entitled to reimbursement for the chronic pain management program rendered on October 3, 2016?

Findings

1. Based upon the submitted *Table of Disputed Services*, the requestor sought dispute resolution for a chronic pain management program rendered from October 3, 2016 through November 4, 2016. After the requestor filed for dispute resolution, the respondent notified the division that payment would be made. The division contacted the requestor to verify that payment was received and if a dispute remained. The requestor noted "Yes, payment was received but DOS 10/03/16 was paid incorrectly." The division concludes that the only service that remains in dispute is the chronic pain management program rendered on October 3, 2016.

2. According to the original explanation of benefits, the respondent denied reimbursement for the chronic pain management program based upon "197-Payment denied/reduced for absence of precertification/authorization." The requestor submitted a copy of a preauthorization report that gives authorization for 80 hours of chronic pain management. The division concludes that a preauthorization issue does not exist in this dispute.

3. The requestor states "Yes, we received the payment but the amount of hours that were paid was incorrect. The total number of hours the patient completed was 8 and the reimbursement was only for 1." In support of the position the requestor submitted medical bills that indicate eight (8) units were billed. The insurance carrier submitted an explanation of benefits that supports payment of $112.50 was issued for October 3, 2016 based upon "P12-Workers compensation jurisdictional fee schedule adjustment."

   To determine if additional reimbursement is due, the division refers to 28 Texas Administrative Code §134.204.

   28 Texas Administrative Code §134.204(h)(1)(A) states "(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR."

   28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs:

   (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

   (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

   A review of the submitted EOBS and bills finds that the requestor billed for 8 hours of CPT code 97799-CP-CA on the disputed date of service. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (5)(A) and (B), the MAR for a CARF accredited program is $125.00 per hour x 8 = $1,000.00. The respondent paid $112.50. The difference between the MAR and amount paid is $887.50. This amount is recommended for additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $887.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $887.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		4/20/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812